OFFICE FINANCIAL POLICY

Thank you for choosing our office for your dental needs. We are committed to the success of your treatment. We hope you understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you read, agree to, and sign prior to treatment. This financial policy applies to all services rendered.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met, and any copay amount due at the time services are rendered. For patients with dual insurance coverage, we will bill both the primary and secondary insurance if you have provided us with the necessary information.

Patients insured with plans with which we are NOT contracted will be required to pay for the first visit in full. For any follow-up visits, you will need to pay your portion of the fees (Example: 20% of fillings and 50% of crowns and root canals, etc.).

If you are insured with a plan with which we ARE contracted, you will need to pay for any non-covered services, any outstanding deductible, and/or copay amount(s) at the time of each visit.

Patients with no insurance coverage are expected to pay for services at the time services are rendered.

A cancellation fee will be charged for a missed or cancelled appointment with less than 24 hours notice.

Our accepted methods of payment are cash, check, Visa, MasterCard, or CareCredit. If requested, a short payment schedule may be arranged for those patients who have special financial conditions.

Again, thank you for trusting us with your care. If you have any questions regarding financial responsibilities or payment options, please contact our billing department.

"I have read, understand, and agree to the provisions of this policy."

Signature of Patient/Guarantor:_____

Print Name:_____ Date:_____